175 Ridge Road
Madison, CT
06443

Mary M. Mushinsky
Assistant Majority Leader
House of Representatives
Legislative Office Building, Room 4038
Hartford, CT 06106-1591

March 14, 2007

Re: House Bill 6404
Act concerning the operation of hydraulic loading and unloading equipment at certain solid waste facilities.

Dear Representative Mushinsky, Chairmen and Distinguished Members,

Thank you for allowing me to present this testimony.

My brother, Robert Gootkin Sr., died on the morning of May 21, 2006. Robert was trapped between the lid and the back wall of a hydraulically operated solid waste loader at the Wallingford, CT waste to energy facility. How Bob got there, is not the point, neither is the fact that this was the first type of accident in approximately sixteen years. The important fact is that a death did occur, that it could have been prevented. My brother was at the end of a twelve-hour night shift, and was alone for probably most of the shift. It took approximately thirty minutes for facility personnel to act, even though alarms were sounding that trash was not being loaded into the incinerators. When I received the call that my brother had died at work, I did not need to hear how. I knew that this piece of equipment had finally killed someone, because it's the most dangerous part of the plant, especially when you are working around it alone.

Up until a few months before Bob's death, it was common practice to have the loader operators go on top of the equipment to clear debris that might damage the machine. Lock out/ tag outs were denied for the reason that it took longer to perform the lock out than it would to clean the machine. The only means of protection the operator had was a multi-position switch located within sight of the machine. I witnessed many times personnel going on the equipment without proper lock out protection. Any protests fell on deaf ears. A few months prior to the incident, a safety evaluation was preformed and it was determined that a lock out would now be needed. Also long handled rakes would be used to pull debris from the top of the loaders. However, when OSHA and the lawyers hired by the estate, requested to see these rakes, none could be provided. I can only presume that the operators were still being required to walk on the equipment.

Covanta claims that training was given to all loader operators concerning the new safety policy for the hydraulic loaders, and that each operator signed off on the training. It was my brother's supervisor who signed off on Bob's training, not Bob. As far as our family is concerned, Bob never received any training. I would like to point out that it took approximately sixteen years for Covanta to allow the operators to use the lock out system for protection, and even this I suspect is not truly being used. The lock out of the four hydraulic valves on the hydraulic loader lid offers the best positive way of assuring the equipment does not move. While I was working there, I often used it, and knew I was safe.

I worked at the facility from October 1989 through November 1999. My position there was lead mechanic in charge of all mechanical equipment. When I first started, I realized quickly that this loading equipment was a death trap if you ever got trapped on it when it activated. Over the years different ideas were presented to make the equipment safer, such as a gate that would lower or an electric eye that would stop movement if someone crossed it. However, nothing meaningful was ever attempted, either because of the cost or it may cause an erroneous shutdown and slow production. The only attempt I can recall is a tarp being mounted in a sloping position to prevent trash from building up on the top of the lid. This lasted about two weeks and was removed. From what I was told and saw in pictures was another attempt at this just after my brother died. Even walking in front of the loader lid can be dangerous. The floor is smooth steel and slippery, especially when wet. I have slipped many times even with good work boots. It's conceivable that someone could slip, fall onto the lid, get injured and not be able to get off in time. This is another reason why an operator should not be alone around this equipment.

During my employment at the plant, cameras were installed in various areas to allow monitoring of the equipment and to watch for fires. The camera on the tipping floor was able to pan back and forth, and angle up and down. It also was able to zoom in. However, this camera was out of service for some time before Bob's death. Management said bids were being sought to replace it. In my opinion, a poor excuse for something that could have made some difference in what happened. Also, why wasn't its replacement expedited for the reason of watching for fires on the tipping floor?

It is my belief that safety should never have a budget limit, and that equipment and conditions can always be improved. Preventing a worker from being alone around a dangerous piece of equipment is a positive safety measure that should be adopted, and would be an acceptable improvement to our family.

Please help prevent such a horrible loss of life from occurring again.

Sincerely,

David A. Gootkin